



**BabyNet**  
South Carolina's Early Intervention System  
SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

\_\_\_\_\_'s  
**Individualized Family Service Plan (IFSP)**

Date of Referral: \_\_\_\_\_ Date of Plan: \_\_\_\_\_

**SECTION 1: CHILD INFORMATION**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: SC Zip Code: \_\_\_\_\_

Gender: M F Race: \_\_\_\_\_ Name of School District and/or Head Start \_\_\_\_\_

Social Security # \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Private Insurance Company Name and Policy # \_\_\_\_\_

**SECTION 2: GENERAL CONTACT INFORMATION**

Parent/Guardian: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
First Last

Home Address: \_\_\_\_\_

Directions to the home: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

E-mail: \_\_\_\_\_

Primary Language/Mode of Communication: \_\_\_\_\_ Interpreter Needed: Y N

Surrogate Parent Needed: Y N Date appointed: \_\_\_\_\_

**Other Contact information**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

**SECTION 3: SERVICE COORDINATION PROVIDER**

BabyNet Service Coordinator (Intake) Name \_\_\_\_\_ Phone \_\_\_\_\_

BabyNet Service Coordinator (Ongoing) Name \_\_\_\_\_

Service Coordination Provider Agency \_\_\_\_\_ Phone \_\_\_\_\_

Other phone \_\_\_\_\_ Email address \_\_\_\_\_

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Name (Last, First, MI): \_\_\_\_\_  
DOB: \_\_\_\_\_  
BabyTrac # \_\_\_\_\_  
Medicaid # \_\_\_\_\_  
CARES # \_\_\_\_\_



**SECTION 5A: FAMILY'S VIEW OF CHILD'S CURRENT HEALTH, CONT.***Refer to BabyNet Birth and Early Health History in completing this section*Does your child use any specialized medical equipment, i.e., oxygen, pulse ox, g-tube, ventilator? ☐ No ☐ Yes

If yes, please list:

**Hearing:** Has your child's hearing been tested? ☐ No ☐ YesIf yes, Date: \_\_\_\_\_ Physician's Name: \_\_\_\_\_ (If the appointment was within 6 months of referral to BabyNet, request the report and **DO NOT** complete Family Hearing and Vision Questionnaire)

Results of hearing evaluation:

If no, proceed with the *Family Hearing and Hearing Questionnaire* and indicate the results: ☐ Pass ☐ Monitor ☐ Refer

Referral to (Physician's name): \_\_\_\_\_ Date of appointment: \_\_\_\_\_

Comments by family or other IFSP team members:

**Vision:** Has your child's vision been tested? ☐ No ☐ YesIf yes, Date: \_\_\_\_\_ Physician's Name: \_\_\_\_\_ (If the appointment was within 6 months of referral to BabyNet, request the report and **DO NOT** complete Family Hearing and Vision Questionnaire)

Results of vision evaluation:

If no, proceed with the *Family Hearing and Vision Questionnaire* and indicate the results: ☐ Pass ☐ Monitor ☐ Refer

Referral to (Physician's name): \_\_\_\_\_ Date of appointment: \_\_\_\_\_

Comments by family or other IFSP team members:

**Nutrition:** Are there any concerns about your child's eating, general nutrition, or growth? ☐ No ☐ Yes☐ Special Formula (specify \_\_\_\_\_) ☐ Avoids certain textures ☐ Food allergies☐ G-tube feedings (Bolus and/or continuous pump) ☐ Will only eat certain foods ☐ Special diet☐ Other, please list (ex., transitioning from G-tube to oral feeding): \_\_\_\_\_

If yes to any conditions listed above please describe:

Comments by family or other IFSP team members:

**Oral Health:** Have your child's teeth or mouth been checked? ☐ No ☐ Yes

If yes, Date: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

How long has/did your child use the following? Bottle \_\_\_\_\_ Mths/yrs Pacifier \_\_\_\_\_ Mths/yrs

Has your child been on any of the following medications for extended periods of time (3 months or more)?

☐ Seizure Medications ☐ Prescription Antibiotics

If yes to any conditions listed above please describe:

Comments by family or other IFSP team members:

Name (Last, First, MI): \_\_\_\_\_

DOB: \_\_\_\_\_

BabyTrac # \_\_\_\_\_

Medicaid # \_\_\_\_\_

CARES # \_\_\_\_\_

**SECTION 5B: HEALTH CARE PROVIDERS**

Provider's Name \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Provider's Name \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

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Address \_\_\_\_\_ Phone \_\_\_\_\_

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BN001

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## SECTION 6A: FAMILY VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION

**Social/Emotional:** Are your child's **social skills** or **emotional development** of concern to you? ☐ No ☐ Yes

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Smiles                  | <input type="checkbox"/> Laughs                             | <input type="checkbox"/> Expresses comfort/discomfort          |
| <input type="checkbox"/> Interest in Peers       | <input type="checkbox"/> Responds to primary caregiver      | <input type="checkbox"/> Anxious when separated from caregiver |
| <input type="checkbox"/> Shows different emotion | <input type="checkbox"/> Shows affection to familiar people |  |

**Other comments (if needed):**

**Communication:** Are your child's **communication skills** of concern to you? ☐ No ☐ Yes

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Tracks movement or sounds with eyes | <input type="checkbox"/> Smiles  | <input type="checkbox"/> Uses single words/phrases |
| <input type="checkbox"/> Grunts                              | <input type="checkbox"/> Points  | <input type="checkbox"/> Talks in sentences        |
| <input type="checkbox"/> Babbles, no words                   | <input type="checkbox"/> Indicates want/needs (looking, sounds, gestures, words) |  |

**Other comments (if needed):**

**Cognitive:** Are your child's **thinking or problem-solving skills** of concern to you? ☐ No ☐ Yes

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Follows moving objects with eyes       | <input type="checkbox"/> Looks at storybook, points to pictures often naming the item | <input type="checkbox"/> Attends to activities of interest for short periods |
| <input type="checkbox"/> Puts small objects in/out of container | <input type="checkbox"/> Imitates actions and words of adults                         | <input type="checkbox"/> Can match two similar objects                       |
| <input type="checkbox"/> Recognizes familiar people             |   |  |

**Other comments (if needed):**

**Self-help skills:** Are your child's **self-help skills** of concern to you? ☐ No ☐ Yes

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Formula/Breast fed only          | <input type="checkbox"/> Needs to be fed              | <input type="checkbox"/> Needs to be dressed         |
| <input type="checkbox"/> Suck-swallow-breath coordination | <input type="checkbox"/> Needs assistance with eating | <input type="checkbox"/> Cooperates with dressing    |
| <input type="checkbox"/> Holds own bottle                 | <input type="checkbox"/> Finger feeds                 | <input type="checkbox"/> Removes socks, shoes        |
| <input type="checkbox"/> Sucks/chews on crackers          | <input type="checkbox"/> Feeds self with spoon        | <input type="checkbox"/> Dresses independently       |
| <input type="checkbox"/> Eats soft food only              | <input type="checkbox"/> Feeds self with fork         | <input type="checkbox"/> Toilet training in progress |
| <input type="checkbox"/> Eats solid foods                 | <input type="checkbox"/> Wears diapers                | <input type="checkbox"/> Fully toilet trained        |

**Other comments (if needed):**

**Motor skills:** Is there anything about how your child **moves** that is a concern to you? ☐ No ☐ Yes

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Head needs support            | <input type="checkbox"/> Can grasp objects with fingers | <input type="checkbox"/> Pulls to standing            |
| <input type="checkbox"/> Holds head steady             | <input type="checkbox"/> Plays with toys, one hand      | <input type="checkbox"/> Cruises holding on to things |
| <input type="checkbox"/> Claps hands, plays patty cake | <input type="checkbox"/> Plays with toys, both hands    | <input type="checkbox"/> Walks with assistance        |
| <input type="checkbox"/> Rolls over                    | <input type="checkbox"/> Scoots                         | <input type="checkbox"/> Walks independently          |
| <input type="checkbox"/> Sits with support             | <input type="checkbox"/> Crawls on hands and knees      | <input type="checkbox"/> Runs                         |
| <input type="checkbox"/> Can grasp objects with hand   |   |   |

**Other comments (if needed):**

Name (Last, First, MI): \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 BabyTrac # \_\_\_\_\_  
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SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION	
Date of IFSP	Child's Name
Child's Chronological or Adjusted Age at time of CBA: ____ years ____ months	
List CBA Tool:	Name and agency of CBA Provider <i>please print</i> :
Overall strengths of child, successful strategies used in the assessment, and factors that may have affected assessment process	
<b>CBA Results for Social –Emotional Domain</b>	
Social-emotional skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay or Area Goal Score in this domain:	
Date CBA conducted	Signature of CBA Provider
BN001	Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 BabyTrac # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 CARES # \_\_\_\_\_

**SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION , CONT.****CBA Results for Cognitive Domain**

Cognitive skills child currently demonstrates:

Skills newly learned/emerging:

Skills not yet learned:

Percentage of Delay or Area Goal Score in this domain:

**CBA Results for Communication Domain**

Communication skills child currently demonstrates:

Skills newly learned/emerging:

Skills not yet learned:

Percentage of Delay or Area Goal Score in this domain:

Date CBA conducted

Signature of CBA Provider

BN001

Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_  
DOB: \_\_\_\_\_  
BabyTrac # \_\_\_\_\_  
Medicaid # \_\_\_\_\_  
CARES # \_\_\_\_\_

**SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION , CONT.****CBA Results for Self-Help/Adaptive Domain**

Self-help/adaptive skills child currently demonstrates:

Skills newly learned/emerging:

Skills not yet learned:

Percentage of Delay or Area Goal Score in this domain:

**CBA Results for Motor Domain**

Gross motor skills child currently demonstrates:

Fine motor skills child currently demonstrates:

Gross motor skills newly learned/emerging:

Fine motor skills newly learned/emerging:

Gross motor skills not yet learned:

Fine motor skills not yet learned:

Percentage of Delay or Area Goal Score in this domain:

Percentage of Delay or Area Goal Score in this domain:

Date CBA conducted

Signature of CBA Provider

BN001

Revised 11/01/2007

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Medicaid # \_\_\_\_\_  
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**SECTION 6C: OTHER TEAM MEMBERS' VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION***To be completed at first IFSP Team's review of the Plan and each Annual IFSP Team Meeting***Social-emotional skills:****Cognitive skills:****Communication skills:****Self-help skills:****Motor skills:**

BN001

Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_  
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BabyTrac # \_\_\_\_\_  
Medicaid # \_\_\_\_\_  
CARES # \_\_\_\_\_

**SECTION 7: FAMILY'S RESOURCES, PRIORITIES, AND CONCERNS (VOLUNTARY BY FAMILY)****Family declined family assessment of resources, priorities, and concerns Parent's initials:** \_\_\_\_\_**Date Family Assessment completed:** \_\_\_\_\_

I have questions about or want help for my child in the following areas (check all that apply):

1	Moving around (crawling, scooting, rolling, walking)
2	Ability to maintain positions for play
3	Talking and listening
4	Thinking, learning, playing with toys
5	Feeding, eating, nutrition
6	Having fun with other children; getting along
7	Behaviors/appropriate interactions
8	Expressing feelings
9	Toileting; getting dressed; bedtime; other daily routines
10	Helping my child calm down, quiet down
11	Pain or discomfort
12	Special health care needs
Other	

Family's remarks regarding concerns identified about their child (including any not listed):

I would like to share the following concerns and priorities for myself, other family members, or my child (check all that apply):

1	Learning more about how to help my child grow and develop
2	Finding or working with doctors or other specialists
3	Learning how different services work or how they could work better for my family
4	Planning for the future; what to expect
5	Parenting skills
6	People who can help me at home or care for my child so I/we can have a break; respite
7	Child care
8	Housing, clothing, jobs, food, or telephone
9	Information on my child's special needs, and what it means
10	Ideas for brothers, sisters, friends, extended family
11	Money for extra costs of my child's special needs
12	Linking with a parent network to meet other families, have information ( <input type="checkbox"/> P2P <input type="checkbox"/> PTIC <input type="checkbox"/> CRS)
Other	

Family's remarks regarding identified priorities of the family (including any not listed):

Strengths, resources that our family has to meet our child's needs (**must** include statement of family's home and community routines and activities):

BN001

Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_  
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CARES # \_\_\_\_\_

## SECTION 8: ELIGIBILITY

### INITIAL IFSP

Eligibility determination date: \_\_\_\_\_  
 Check one of the following:

☐ **Not eligible**

☐ **Established Risk:** Written documentation of a diagnosis listed in the BabyNet Manual.

☐ **Established Risk (not otherwise specified):** Written confirmation by DHEC pediatric consultant that child's condition or diagnosis meets eligibility criteria.

Diagnos(es):  
 \_\_\_\_\_  
 \_\_\_\_\_

☐ **Developmental delay** based on curriculum-based assessment (CBA) as documented below.

☐ **Developmental delay** as determined by informed clinical opinion and documented on ICO form per BabyNet manual requirements.

### ANNUAL IFSP

**IFSP Date:** \_\_\_\_\_  
 Check one of the following:

☐ **No longer eligible**

☐ **Established risk:** condition previously documented continues.

☐ **Established risk (not otherwise specified)** condition previously documented continues.

☐ **Developmental delay** Curriculum-based assessment (CBA) reveals delay greater than 15% in any one domain. (ANNUAL evaluation of the IFSP only. Eligibility continues unless present level of performance in all domains has progressed to within normal limits [i.e., delays are equal to or less than 15% in all domains]).

IDEA/Part C (BabyNet) services are continued in order to (*check one*):

☐ Prevent regression (developmental losses)

☐ Continue developmental gains

☐ Help child reach developmental status of same-aged-peers

**Curriculum-Based Assessment (CBA) Tool used:**

### Delay by Developmental Domain (percentage or Area Goal Score)

Social-Emotional \_\_\_\_\_  
 Cognition \_\_\_\_\_  
 Communication \_\_\_\_\_

Self-Help \_\_\_\_\_  
 Gross Motor \_\_\_\_\_  
 Fine Motor \_\_\_\_\_

### Eligibility Determination Team Signatures, Participation

Name (printed)	Signature	Agency	On-site	Off-site

BN001

Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 BabyTrac # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 CARES # \_\_\_\_\_

<p align="center"><b>SECTION 9: OTHER SERVICES</b></p> <p>An ‘other service’ is a service necessary or desired to assure optimal child and/or family functioning; but not part of IDEA Part C or covered by BabyNet.</p> <p>Other Services include, but are not limited to, housing, food stamps, WIC, TEFRA, clothing, respite, PCA, MR/RD Waiverservice, including services in place at the time BabyNet eligibility established or added during implementation of the IFSP.</p>
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BN001	Revised 11/01/2007
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Name (Last, First, MI): \_\_\_\_\_

DOB: \_\_\_\_\_

BabyTrac #

Medicaid # \_\_\_\_\_

CARES # \_\_\_\_\_

**SECTION 10A: CHILD/FAMILY CENTERED GOAL**

A goal is a statement of change the family would like to see happen for themselves and/or their child.

**Goal #:****Date of Goal:****Target Date:****GOAL:** What knowledge, skill or behavior would we like to learn or see learned by our child?**MEASURING PROGRESS:**

What difference will this make for our child and/or family?

How will we know when the goal has been met? List specific skills from the CBA that are components of this goal

**NATURAL SUPPORTS:** Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and places**ADAPTATIONS AND/OR MODIFICATIONS:** Special accommodations/adaptations/equipment that can help make this happen (Assistive Technology).**SERVICES TO CONSIDER:** What Part C and/or Other services are needed in order to achieve this goal in everyday routines, activities, and places?**WILL ALL SERVICES BE PROVIDED IN THE CHILD'S HOME & COMMUNITY ROUTINES & ACTIVITIES?**☐ Yes ☐ No: If no, check one: ☐ Developmental/Medical Conditions ☐ No Available Providers ☐ Other:**JUSTIFICATION/EXPLANATION FOR PART C SERVICES OUTSIDE OF THE NATURAL****ENVIRONMENT:** What are the developmental, medical or other conditions that would require the service to be provided outside the family's home & community routines & activities?**Service****Describe any interventions and/or efforts to provide services in everyday routines, activities, and places (RAP's) that were conducted and why these have been determined by the Team to be unsuccessful. The justification must include a plan for how services provided in any specialized setting will be generalized into the child's RAP's.**

BN001

Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_

DOB: \_\_\_\_\_

BabyTrac # \_\_\_\_\_

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**SECTION 10B: PERIODIC REVIEW OF GOAL**

*Goals may be reviewed, modified, and/or discontinued at any time but review period must not exceed 6 months.  
See IFSP Change Review, IFSP Six-Month Review and Annual IFSP Goal Attainment Scale information on the following page.*

**Goal #:**      **Date Reviewed:**      ☐ **Change Review**    ☐ **6-month Review**    ☐ **Annual Evaluation**

- |   |  |
|---|--|
| <input type="checkbox"/> 1-Situation changed, no longer needed<br><input type="checkbox"/> 2-Situation changed, is still needed<br><input type="checkbox"/> 3-Intervention started, is still needed<br><input type="checkbox"/> 4-Goal partially attained/accomplished but not to team's satisfaction | <input type="checkbox"/> 5-Goal attained or accomplished but not to team's satisfaction<br><input type="checkbox"/> 6- Goal mostly attained or accomplished to team's satisfaction<br><input type="checkbox"/> 7- Goal attained or accomplished to the team's satisfaction |
|---|--|

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments:

**Goal #:**      **Date Reviewed:**      ☐ **Change Review**    ☐ **6-month Review**    ☐ **Annual Evaluation**

- |   |  |
|---|--|
| <input type="checkbox"/> 1-Situation changed, no longer needed<br><input type="checkbox"/> 2-Situation changed, is still needed<br><input type="checkbox"/> 3-Intervention started, is still needed<br><input type="checkbox"/> 4-Goal partially attained/accomplished but not to team's satisfaction | <input type="checkbox"/> 5-Goal attained or accomplished but not to team's satisfaction<br><input type="checkbox"/> 6- Goal mostly attained or accomplished to team's satisfaction<br><input type="checkbox"/> 7- Goal attained or accomplished to the team's satisfaction |
|---|--|

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments:

**Goal #:**      **Date Reviewed:**      ☐ **Change Review**    ☐ **6-month Review**    ☐ **Annual Evaluation**

- |   |  |
|---|--|
| <input type="checkbox"/> 1-Situation changed, no longer needed<br><input type="checkbox"/> 2-Situation changed, is still needed<br><input type="checkbox"/> 3-Intervention started, is still needed<br><input type="checkbox"/> 4-Goal partially attained/accomplished but not to team's satisfaction | <input type="checkbox"/> 5-Goal attained or accomplished but not to team's satisfaction<br><input type="checkbox"/> 6- Goal mostly attained or accomplished to team's satisfaction<br><input type="checkbox"/> 7- Goal attained or accomplished to the team's satisfaction |
|---|--|

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments:

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SECTION 11: SERVICE COORDINATION GOALS	
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BN001

Revised 11//01/2007

Name (Last, First, MI): \_\_\_\_\_  
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 BabyTrac # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 CARES # \_\_\_\_\_

## SECTION 12: TRANSITION PLANNING

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Name (Last, First, MI): \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 BabyTrac # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 CARES # \_\_\_\_\_

<b>SECTION 13: BABYNET SERVICES</b>			
<input type="checkbox"/> Add Service <input type="checkbox"/> Discontinue Service <input type="checkbox"/> Continue Service     Date of IFSP Linked to Service:			
<input type="checkbox"/> Parent refuses/requests discontinuation of this service		Parent Initials: _____ Date: _____	
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date: _____ Planned End Date: _____	
Actual Start Date:	Actual End Date:	Method CODE:	Fund CODE(s):
Setting CODE:	Visit Duration in Minutes:	Number of Visits: _____ <div style="display: flex; justify-content: flex-end; gap: 10px;"> <input type="checkbox"/> Week     <input type="checkbox"/> Month  <input type="checkbox"/> Every Other Month  <input type="checkbox"/> Quarterly           </div>	
Travel Only: <input type="checkbox"/> No <input type="checkbox"/> Yes     CODE: _____		If required, is service setting justified? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE:			
<b>SECTION 13: BABYNET SERVICES</b>			
<input type="checkbox"/> Add Service <input type="checkbox"/> Discontinue Service <input type="checkbox"/> Continue Service     Date of IFSP Linked to Service:			
<input type="checkbox"/> Parent refuses/requests discontinuation of this service		Parent Initials: _____ Date: _____	
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date: _____ Planned End Date: _____	
Actual Start Date:	Actual End Date:	Method CODE:	Fund CODE(s):
Setting CODE:	Visit Duration in Minutes:	Number of Visits: _____ <div style="display: flex; justify-content: flex-end; gap: 10px;"> <input type="checkbox"/> Week     <input type="checkbox"/> Month  <input type="checkbox"/> Every Other Month  <input type="checkbox"/> Quarterly           </div>	
Travel Only: <input type="checkbox"/> No <input type="checkbox"/> Yes     CODE: _____		If required, is service setting justified? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE:			
<b>SECTION 13: BABYNET SERVICES</b>			
<input type="checkbox"/> Add Service <input type="checkbox"/> Discontinue Service <input type="checkbox"/> Continue Service     Date of IFSP Linked to Service:			
<input type="checkbox"/> Parent refuses/requests discontinuation of this service		Parent Initials: _____ Date: _____	
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date: _____ Planned End Date: _____	
Actual Start Date:	Actual End Date:	Method CODE:	Fund CODE(s):
Setting CODE:	Visit Duration in Minutes:	Number of Visits: _____ <div style="display: flex; justify-content: flex-end; gap: 10px;"> <input type="checkbox"/> Week     <input type="checkbox"/> Month  <input type="checkbox"/> Every Other Month  <input type="checkbox"/> Quarterly           </div>	
Travel Only: <input type="checkbox"/> No <input type="checkbox"/> Yes     CODE: _____		If required, is service setting justified? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE:			
<b>BN001</b>			

**Revised 11/01/2007**

Name (Last, First, MI): \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 BabyTrac # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 CARES # \_\_\_\_\_

**SECTION 14: INITIAL AND ANNUAL IFSP CONSENT AND TEAM SIGNATURES****IFSP Meeting Notes:****Type of IFSP:** ☐ **Initial IFSP** ☐ **Change Review** ☐ **Six Month Review** ☐ **Annual IFSP****Accepting BabyNet Part C Services Recommended by the IFSP Team**

- I have received a copy of my rights under Part C of IDEA (*Notice of Child and Family Rights in the BabyNet System*) and these have been explained to me along with this IFSP.
- My consent is voluntary and based on my understanding of the activities, which have been explained to me in my native language or mode of communication.
- I understand that my consent remains in effect until the next IFSP or IFSP Review and that I may revoke my consent in writing, at any time.
- I understand that I may decline a service or services without jeopardizing any other BabyNet service(s) my child or family receives.
- I understand that my IFSP will be shared among the service providers implementing this IFSP, others I may identify, and entities within the system per federal reporting requirements.

I have participated in the development of this plan, and give informed consent for BabyNet to carry out the activity/activities on this IFSP: ☐ Yes ☐ No

Signature of Parent(s):

Date:

**IFSP Team Members****Method Codes:** A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature/Name	Role	Agency (if applicable)	Method Code	Date
	BN Service Coordinator			

BN001

Revised 11/01/2007

Name (Last, First, MI): \_\_\_\_\_

DOB: \_\_\_\_\_

BabyTrac # \_\_\_\_\_

Medicaid # \_\_\_\_\_

CARES # \_\_\_\_\_

## SECTION 15: MEDICAL AND THERAPY UPDATES

[illegible]

BN001	Revised 11/01/2007
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BN001	Revised 11/01/2007
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Name (Last, First, MI): \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 BabyTrac # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 CARES # \_\_\_\_\_